REPORT ON THE RHODE ISLAND EARLY INTERVENTION SYSTEM: FUTURE DIRECTION AND ACCOMPLISHMENTS, PART II

Submitted to:

The Honorable Representative Eileen S. Naughton

Submitted by:

Ronald A. Lebel, Acting Director
Rhode Island Department of Human Services

February 4, 2005

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I. Introduction

Budget Article 44, effective July 1, 2004, transferred the administration of the State's Early Intervention (EI) System from the Rhode Island Department of Health (HEALTH) to the Rhode Island Department of Human Services (DHS). Section 23-13-22(b) of Act H 8669 required "an evaluation plan describing outcome measures that document the system's successes and shortcomings from the previous fiscal year be submitted to the speaker of the house of representatives, the president of the senate and the house oversight committee and the governor and the interagency coordinating council." This report was submitted on November 5, 2004.

Additionally, within six (6) months, it is required that DHS shall report on (A) prescribed outcomes documented in the evaluation plan, including written explanation for those not yet accomplished, (B) the progress of coordination of efforts with HEALTH, the Department of Education (RIDE), the Interagency Coordinating Council (ICC) and other stakeholders, as well as (C) recommendations regarding modifications to reimbursement mechanisms. This document is intended to fulfill these requirements.

II. Evaluation Plan

(A) Early Intervention System Outcomes

Below is a list of perceived challenges within the EI system as identified in the last report. DHS and its collaborative partners (as noted above) are proud to report on the successes/accomplishments since the last report. They are outlined below:

1. *The Rhode Island EI System is in transition from one lead agency to another.*

Transition was officially effected as of January 1, 2005. DHS met its commitment of ensuring that there were no changes or interruptions in EI services for families. Numerous activities facilitated this process occurring smoothly and include:

- Multiple informational mailings to EI families and other stakeholders
- Informal surveying of parent consultants, specialty providers, Pediatricians and Local Education Authorities (LEAs)
- EI provider site visits designed to foster relationships and collect information/ recommendations for system improvement
- Negotiation and consideration of EI contracts refined in collaboration with current HEALTH programs
- Transfer of three (3) HEALTH staff to DHS with appropriate equipment/supplies
- Appropriate DHS staff trainings and orientations complete

2. *The system has experienced financial instability due to budget fluctuations. Providers lack confidence in the predictability of reimbursement procedures and the timeliness of payments. In turn, providers have been reluctant to hire staff to meet the demand and requirements (e.g., timeliness of services).*

Careful consideration around EI system financial instability has been at the center of DHS' work. As a result, DHS' goal to ensure that the eligibility and claims payment systems are ready to process and pay claims by January 1, 2005 has been realized. Numerous activities facilitated this process occurring smoothly and include:

- Local codes cross-walked with national codes as required under the Federal HIPAA mandate
- Billing codes revisited and reworked to allow for more appropriate reimbursement and adequate federal reporting
- Technical Assistance (TA) meetings and communications for EI providers, Medicaid Managed Care health plans, and commercial insurers around Article 22 mandate
- Individual TA sessions with specialty providers new to Medicaid fee-for-service model
- Draft of new OSEP application currently being reviewed which will allow for the transfer of Federal EI funds from HEALTH to DHS

3. *Problems exist with timely access to some services and timely initiation of services (related to professional capacity).*

Early on, DHS recognized the capacity of the EI system to be problematic and has worked toward creative solutions. The formation of a Capacity Subcommittee has begun to institute numerous activities toward improving timely access to EI services and includes:

- EI Operational Standards revised to allow for reimbursement of paraprofessionals
- Surveys of EI providers to identify current best practices
- Rewrite of certification standards has begun in order to further address capacity and other programmatic constraints
- Revision of Certification Standards to be released prior to re-certification of current EI providers to improve quality assurance procedures and provider compliance
- Surrogate parent program transferred to DHS
- Consideration of CAPTA legislation and potential impact to EI system—ICC subcommittee working in conjunction with DCYF to determine most streamlined method of handling new referrals
- Exploring potential for building expanded professional development capacities into University of Rhode Island (URI) contract

4. *Parents perceive that the intensity or amount of services for some populations/conditions is inadequate.*

Strong collaboration with the Rhode Island Parent Information Network (RIPIN) as well as parent representatives from the ICC has begun to remedy this perception. A disconnect between the medical community and EI system philosophy has been identified. As a result, two 'world views' are often presented to families inquiring about and/or utilizing EI services. As a result, a Public Awareness subcommittee with collaborative membership (DHS staff, ICC reps, and EI providers) has begun to address this through numerous activities that include:

- Improved and streamlined EI communication materials
- Revised Certification Standards will require EI providers to improve upon and report to DHS current public awareness activities specific to EI philosophy including Natural Environments
- Outreach/education efforts to physician/pediatrician community will be piloted by DHS

5. *The system has shortfalls in the cultural and linguistic competency of its providers, staff, and materials.*

DHS' commitment to provide programs and services to underserved populations throughout the state of Rhode Island has been nationally recognized. The integration of the EI system into DHS will enable the use of similar methods to address this challenge within the EI system. These activities include:

- Bi-Lingual DHS Info Line available to all families with appropriately trained staff to answer questions regarding EI and to direct more pertinent calls
- Improved, streamlined and culturally competent EI communication materials designed to better reach Rhode Island's underserved populations
- Identification of provider non-compliance with Certification Standards through the comparison of state/area demographics with demographics of the children served by individual EI providers
- Reporting requirements for EI providers around cultural competency, diversity of staff, and outreach activities to underserved populations as part of compliance under amended Certification Standards

6. *For those children who do not qualify for Preschool Special Education and/or need additional services, other systems services and resources have not been accessed extensively and/or consistently.*

While under HEALTH, the EI system greatly improved transition processes for children entering Special Education. However DHS' commitment to the health and well being of all children and the extensive network of services and benefits available to children

necessitates an improved approach to EI transition. This approach will involve numerous activities that include:

- Use transition staff to implement new method/instrument to collect data on all children exiting EI, (i.e. not only those transitioning to Special Education)
- New EI provider reporting requirement as part of Certification Standards regarding services accessed
- EI Provider and Physician/Pediatrician education regarding medical home linkages and referrals to community resources and supports

III. Early Intervention Vision

In the November report, DHS outlined five (5) overall goals. The following delineates measurable programmatic indicators for each goal that will be implemented and monitored over the next twelve (12) months by DHS. Additionally, the Annual Performance Report (APR) submitted to the Office of Special Education Programs (OSEP) requires comprehensive outcome data for EI programs and can be accessed for additional information.

Goal #1: All eligible infants and toddlers are identified, evaluated, and enrolled with particular attention to reaching those with the highest risks and needs.

Indicator #1: What percent of children under the age of one (1) are identified as eligible for EI enrolled in EI? How is this percentage comparable with State and national data?

Method #1: Compare Kidsnet* data to EIMIS and federally reported data

Goal #2: Services are tailored to optimize each individual child's potential and to address family needs. Services are offered in a variety of natural environments and in an inclusive manner.

Indicator #2: Does the timely evaluation and assessment of child and family needs lead to identification of all needs related to enhancing the development of the child?

Method #2: Compilation of questions on RIPIN family survey to determine yearly trends

***KIDSNET is a Department of Health integrated information management and tracking system for children in Rhode Island. KIDSNET provides policymakers and citizens with indicators of child well being, seeking to enrich local, state, and national discussions concerning ways to secure better futures for all children**

Indicator #2a: Are all the services identified on IFSPs provided?

Method #2a: Build query of IFSP screen in EIMIS to examine timeliness of services based on DHS determined standards

Goal #3: All participating children have a successful transition to appropriate systems and services when they reach age three.

Indicator #3: Do ALL children exiting Part C receive the transition planning necessary to support the child's transition to preschool and other appropriate community services and supports by their third birthday?

Method #3: A reporting tool will be developed that requires EI providers to present appropriate referrals to related programs, community resources and supports.

Goal #4: Available funds (public and private) are leveraged and services are coordinated to better serve more infants and toddlers with developmental delays and disabilities.

Indicator #4: Where appropriate, is commercial insurance identified, accessed, and billed for EI services?

Method #4: Report amount of dollars billed to commercial insurers for EI services.

Goal #5: Based on Individualized Family Service Plans (IFSPs), appropriate and accessible providers are available for the array of interventions needed by EI infants, toddlers, and their families.

Indicator #5: Are there sufficient numbers of staff in each discipline to meet the identified early intervention needs of all eligible infants, toddlers and their families?

Method #5: EI providers report on staffing capacity — DHS to develop acceptable ratios.

(B) Coordination of Efforts

The above activities represent the collaborative efforts of state agencies such as DHS, HEALTH, RIDE, and DCYF and also those between EI families, EI providers, parent consultants and the ICC. Specific examples of ongoing coordination include:

- Annual Performance Report and contracts negotiations with HEALTH
- Interagency agreements and Joint Part B and Part C meetings with RIDE

- Staff representation at DHS EI organizational meetings, review of all materials and reports, and appropriate representation on various subcommittees with ICC
- CAPTA legislation work with DCYF

(C) Modification of Reimbursement Mechanisms

As noted above, a great deal of work has been done to improve EI system reimbursement mechanisms. This includes extensive technical assistance around the Article 22 mandate effective January 1, 2005. It is the hope and goal of DHS that by improving the financial stability of EI providers, more general programmatic improvements can be facilitated. Efforts around finalizing an effective billing and claims system for both Medicaid and non-Medicaid eligible children has required the concentrated effort of DHS and Electronic Data Systems (EDS) staff members, as well as significant input from EI providers and families.

The following documents outlining modifications and improvement of EI reimbursement and Article 22 implementation are enclosed:

- Communication/announcement materials
- Technical Assistance materials
- National codes crosswalk

IV. Closing

DHS is proud to present this report to your committee and believe that it highlights our commitment to the delivery of the highest quality of services for all families in Rhode Island. Our multi-faceted collaborative approach and team efforts continue to position DHS, as the Lead Agency, on the road toward an ever-improving EI system, accessible and responsive to all Rhode Island children and families, as well as all EI certified and specialty providers.

SUPPORTING DOCUMENTS

December 15, 2004

Dear Family,

The General Assembly's decision to change management responsibility for Rhode Island's Early Intervention Program has led to some recent changes. The Department of Human Services (DHS) will now manage the Early Intervention Program, previously managed by the Department of Health (DOH). The transition of the Early Intervention (EI) system is well under way and DHS is committed in making sure that the services families are receiving will continue without any interruption.

One great piece of this transition is a mandate requiring that all health insurance companies cover children in Early Intervention up to $5,000 per child, per year beginning January 1st, 2005. This mandate states that this benefit coverage will not result in families paying any deductibles or co-payments and will not affect any "annual or lifetime maximum benefit" under your health insurance plan.

As a result of this insurance mandate, EI will begin to access your private health insurance to help cover the costs of your child's services listed in your IFSP. Your EI provider will ask you for your private insurance information along with your child's social security number. This information is necessary in order for us process payments from your insurance company. We want to assure families that the information you give your EI provider will be kept completely confidential.

Attached to this letter is a Question & Answer sheet that will help you understand what this "mandate" means for you and your family. If you would like to speak to someone in regards to this letter you may contact your EI Parent Consultant and/or EI Provider.

Sincerely,

John R. Young, C.P.M
Associate Director

What does this "legislative insurance mandate" mean for my family and me?

Q. Will using my private health insurance change the services my child and family are receiving in Early Intervention?

A. No. This insurance mandate WILL NOT change the services your child and family are already receiving in EI. Services will continue as they have the only difference will be that your insurance company will be covering the cost of the services your child receives in EI.

Q. Will I have to pay for any services after the $5,000 my insurance company covers are exhausted for the year?

A. No. DHS will pay for services not covered by your insurance company. Therefore, your family will not have to pay for any EI services.

Q. Will I have to pay any co-payments or deductibles for services in EI?

A. No. DHS pays for co-pays and deductibles. Therefore, your family will not have to pay for co-pays or deductibles.

Q. Will accessing my private insurance to cover EI services affect any coverage benefits I may need for my child in the future or any "lifetime maximum benefits" my insurance company may have?

A. No. The legislative mandate states that accessing your insurance to cover EI services will not affect any "lifetime maximum benefits" you may have under your health insurance plan.

Q. Why do Early Intervention providers need information about my private insurance for Early Intervention Services?

A. This legislation is a mandate for private insurance carriers. EI providers are therefore required to access your private health insurance to cover the costs of Early Intervention. Sharing the costs of EI services with insurance companies will help us build a better and stronger EI system for you and your family.

Q. Why do Early Intervention providers need my child's social security number to access benefits?

A. **EI providers will be asking you for your child's social security number along with your health insurance information in order to process payment for the services your child receives in EI. We assure families that this information is kept completely confidential and will not be used for any other reason but to process payment of EI services your child receives. If you have any questions relating to the confidentiality of information please call your EI Parent Consultant we have included a contact list with contact information.**

December 6, 2004

Dear Health Plan CEO:

As we move forward to transition administration of the Early Intervention (EI) program from the Department of Health (HEALTH) to the Department of Human Services (DHS), we want to provide you with additional information as well as clarify our expectations regarding the coverage of EI services by commercial and RIte Care health plans.

As you are aware, all health insurers licensed in the state of Rhode Island will be required to cover Early Intervention services beginning January 1, 2005. Attached you will find a copy of the legislation (Article 22 of H8219).

I would like to clarify DHS's goals and priorities for the transition of EI program services as covered benefits under all health insurances licensed to operate in Rhode Island. These are the same goals we have for the transition from HEALTH to DHS:

1. There will be a smooth transition for children and families in EI, with no interruption or disruption of services.
2. There will be a smooth transition of billing and payment for EI services, including timely and accurate payment to individual providers.

More specifically, our expectation for insurers is that by January 1, 2005, all insurers will be ready to accept, process and pay claims for EI services to all EI providers within 30 days of receipt of a claim. EI providers must be ready to submit claims to insurers for this transition to occur successfully.

DHS has already taken on the responsibility of paying EI providers for EI services for all enrolled children. Attached you will also find a list of EI services, codes and reimbursement rates. There may be a few additional codes pertaining to specific services, such as audiology, forthcoming. Any additional information will be provided as soon as possible. There will be no prior authorization requirements on the EI service codes attached. It is important to note that families should never receive a bill for early intervention services including co-pays and deductibles.

Also enclosed is a listing of the EI provider network. You will need to ensure that all early intervention providers are credentialed and enrolled in your network. Since some of the providers do not have significant experience with billing private insurers, it will be necessary for you to have a plan in place to provide technical assistance. To facilitate communications with both providers and DHS, we are requesting that you identify a project manager who will serve as the contact point for DHS as well as a provider representative who will be responsible for communication and trouble shooting with the EI sites. **Please send your contacts to Michelle**

Mickey at DHS who can be reached at mmickey@dhs.ri.gov or at 462-6318 (tel.) by December 10, 2004.

As January 1st is rapidly approaching, DHS will convene a meeting from 9:00am to 11:00am on December 15, 2004 at the Meeting Street Center located at 667 Waterman Avenue in East Providence. This will be an opportunity for the insurers, providers, and other early intervention stakeholders to discuss how the implementation of the insurance mandate will work. Accordingly, we expect that you will be able to present your plans for implementation of this mandate.

To assure the smoothest implementation possible, I would ask that you advise prior to the December 15th meeting your readiness to implement these provisions effective for dates of service of January 1, 2005 and after. We are confident that all parties can work together to make this endeavor successful. Thank you for your continued partnership in this endeavor.

Sincerely,

John R. Young, C.P.M.
Associate Director

December 4, 2004

Dear Early Intervention Provider:

As we move forward to transition administration of the Early Intervention (EI) program from the Department of Health (HEALTH) to the Department of Human Services, we want to provide you with information regarding the coverage of EI services by private and RIte Care insurers. As you are aware, all insurers licensed in the state of Rhode Island will be required to cover Early Intervention services beginning January 1, 2005. Please continue collecting third party insurance information from all families enrolled in your EI program. Be sure to check the Recipient Eligibility Verification System (REVS) for availability and updates of third party billing coverage. Attached you will find a list of EI services, codes and reimbursement rates. There may be a few additional codes pertaining to specific services, such as audiology, forthcoming. Any additional information will be provided as soon as possible.

I would like to clarify DHS's goals and priorities for the transition of EI program services as covered benefits under all health insurances licensed to operate in Rhode Island. These are the same goals we have for the transition from HEALTH to DHS:

3. There will be a smooth transition for children and families in EI, with no interruption or disruption of services.
4. There will be a smooth transition of billing and payment for EI services, including timely and accurate payment to individual providers.

Our goal is to continue to facilitate access to EI services for children and families. We expect that no families will be billed for EI services. There are no prior authorization requirements on the services provided in the attached codes crosswalk.

It is our expectation that by January 1, 2005, all insurers will be ready to accept, process and pay claims for EI services to all EI providers within 30 days of receipt of a claim. EI providers must be ready to submit claims to insurers for this transition to occur successfully.

You will need to ensure that your program is credentialed and enrolled with all network providers and that claims are submitted in an acceptable format. To facilitate communications with both insurers and EI providers DHS is working with network providers to identify a provider representative who will be responsible for communication with the EI sites.

As January 1st is rapidly approaching, DHS will convene a meeting from 9:00am-11:00am on December 15, 2004 to be held at the Meeting Street Center at 667 Waterman Avenue in East Providence. This will be an opportunity for the insurers, providers, and other early intervention stakeholders to discuss how the implementation of the insurance mandate will work. We are

confident that all parties can work together to make this successful. Thank you for your continued partnership in this endeavor.

Sincerely,

John R. Young, C.P.M.
Associate Director

Early Intervention Services, Coding, Reimbursement, Etc.
Frequently Asked Questions

Frequently Asked Questions (FAQ) from January 21, 2005

1. Where do we send forms that pre- approve conference reimbursement time for staff?
    - Continue to send them to Cynthia Holmes.

2. What are we doing about the 990 code?
    - Please continue to use 990 to track parent consultant visits and other non-billable services.

3. Are we required to make unpaid visits to integrated groups?
    - Technically the state is paying for support to integrated group. Please continue to follow standards set by HEALTH including the tracking of the support visit by using the 990 code. These regulations will be reviewed by DHS in the near future.

4. Will be able to know what our revenue is for each billing period?
    - Providers will have to use their Remittance Advice from Medicaid/EDS and their Explanation of Benefits (EOB) from the commercial carriers to calculate their revenue.

5. Will there be a new report to let us know all billing for the time period now that we are no longer back billing?
    - All billing to Medicaid/EDS will be reported on the Remittance Advice. The Remittance Advice lists the claims in alphabetical order by Recipient Last Name.

6. How should denied claims be processed?
    - Denied claims from EDS should be reprocessed with the corrected information. Karen Murphy can provider assistance with understanding a denial reason. Denials from the commercial carriers should be followed up with the appropriate Carrier.

Frequently Asked Questions (FAQ) from January 13, 2005

1. Will there be a new form to replace the third party access form? And if so, when will it be available?
    - The third party access form is no longer needed. Due to Article 22, parents should no longer be given the option of using their commercial insurance. Insurance information should be collected at intake.

2. Is the supervision and file management going to be billed to the commercial insurances?
    - Yes, <u>all</u> EI services should be billed to commercial insurance. These are child specific and should be documented in the child's record.

3. How is the payment for medical records billed?
    - Documentation for File Management is recorded on a SRF, which is filed in a child's record. The SRF should state the number of days a child received file management for the month.

4. Regarding supervision, if we are now billing through a SRF how will the statistics be effected in terms of marking whether services occurred in a natural environment (and if file management is billed on a SRF how will that also effect the statistics)?

- Just to be clear, the provider should document supervision on an SRF, however, these services should be billed to EDS on a claim form. With regard to the stats, file Management and supervision will be identified and separated from other services.

5. Will providers be able to use the current SRF for supervision or will be have to use the new SRF which is more geared for the notes on our work with the family?
    - Use the current SRF until the new SRF is in place.

6. Is it possible for EI programs to use the national codes when EDS is ready to accept them, instead of using them now only in EIMIS? The concern is that it creates more work for the providers to have to convert the national codes to the x codes for billing.
    - Unfortunately not. The reason we have required the use of national codes in the EIMIS beginning February 1 is for efficient data collection, reporting and management. We also assumed that this process would make it easier for the direct care providers since national codes must be billed to the commercial carriers for dates of service after 1/1/05.

7. What is the ability for service coordinator I's to do IFSPs and progress reviews?
    - There was an error in the Crosswalk list handed out at the meeting. The IFSP and progress review meetings CAN be done by level 1 staff.

8. A child will only be reimbursed for group services up to 2 hours per week. Is that only for billing for a 254 and 258 services?
    - Changes have been made which affect several codes. Please see new crosswalk for each code. The units are accurate for each service. These services will be reviewed by DHS in the near future.

Frequently Asked Questions (FAQ's) from January 12, 2005

1. File management is now billable at a rate of .33 per child per day. Does this mean we need to enter all children each day?
    - File Management is now a child specific service. Providers should span bill this service for the month for each child. The units would be the # of days the child is enrolled in EI for that month. The total $ billed would be the rate (33 cents per day) times the # of units.

2. How should providers be billing for supervision? What documentation is needed?
    - Providers billing for supervision must meet the criteria stated in the Operational Standards for a clinical supervisor. Supervision is now a child specific service. The maximum allowed is 30 minutes per child per month and the service must be documented in the child's record.

3. What are we doing with families who deny access to their private insurance?
    - The Mandate, Article 22, states that providers can and should access a child's private/commercial insurance. If a family refuses to provide the necessary information but Medicaid is able to determine that the child has private/commercial insurance then that information is shared with the providers through our Recipient Eligibility Verification System (REVS) and the provider should bill the private/commercial insurance accordingly.

4. Is the patient's co-pay and deductibles a part of the $5000 benefit?
    - No, there are no co-pays or deductibles for Early Intervention Services.

5. How should we be billing for the non-direct service (file management and supervision) codes?
    - Non-Direct Services are now child specific services. See item #1 above for documentation about file management. Supervision is reimbursable in 15 minute units at a Bachelor's Level, Master's Level, or Doctoral Level. Please see item #2 above.

6. What is a managed care indicators?
    - For children on Rite care with a claim for dates of service between 10/1/2004 and 12/31/2004, the Managed Care Indicator (MC Ind column on the crosswalk spreadsheet) notifies the provider if the service should be billed to the Plan the child is enrolled in or to EDS. An 'I' indicates an In Plan service – billable to the Plan and an 'O' indicates an Out of Plan service – billable to Medicaid/EDS. All claims after 1/1/2005 will be billed to the Plans for Rite care children.

7. How do we bill for case conferences?
    - Case Conferences should continue to be billed as they currently are now. With the addition of services and some services becoming child specific, the provider should utilize the most appropriate codes when billing case coordination. For example Treatment Consultation and Clinical Supervision. Further guidance to follow.

8. What are the new codes? Billing rates? Personnel qualified to bill for each service?
    - Please refer to the Codes Crosswalk

9. Integrated group? Will daycare be paid for? Do daycare providers need to be certified for commercial payers?
    - Daycare providers do not need to be certified by the Commercial Insurers. Daycare providers should be licensed by DCYF. DHS is reviewing policy around this service. Further information to follow.

10. Out of State Billing?
    - If unsure about an out of state commercial coverage contact Department of Business Regulations (DBR) to inquiry about the license status of the other coverage. If the out of state coverage is licensed in RI, then bill for the EI services until the benefit is exhausted. If the out of state coverage is not licensed in RI, then bill to the other coverage to receive the denial then bill Medicaid/EDS with the Explanation of Benefits (EOB). For all subsequent claims, utilize the Coordination of Benefits form (See Handout) in lieu of an EOB, to attach to the paper claims submitted to Medicaid/EDS.

11. Adjustments?
    - If the provider has inadvertently billed EDS for the national codes, please submit an adjustment request form asking that the $ be recouped then bill the appropriate local (X code) code.

Claims for Dates of Service 10/1/2005 – 12/31/2004

	Children with Medicaid Only	**Children w/ Dual Coverage (Managed Care & MA of Commercial & MA)**	**Children with Commercial Coverage Only**
EDS	Bill X codes for all direct services (this does not include file management or supervision)	Bill X codes for all Out of Plan (OOP)services for kids with managed care & MA. See MC Ind. on code spreadsheet, I for in plan and O for out of plan.	Bill X codes for all direct services not covered by Other Insurers (these are claims that typically went to DOH).
RIte Care Plans	N/A	Bill all In Plan (IP) services to the appropriate plan and continue to bill EDS for out of plan (OOP) services. See MC Ind. on code spreadsheet, I for in plan and O for out of plan.	N/A
Commercial Carriers	N/A	Bill the Commercial Carriers for services covered then balance bill MA as usual.	Bill the Commercial Carriers for services covered.

Claims for Dates of Service 1/1/2005 and Ongoing

	Children with Medicaid Only	**Children w/ Dual Coverage (Managed Care & MA of Commercial & MA)**	**Children with Commercial Coverage Only**
EDS	Bill X codes for all services until further notice. This includes direct and non-direct (file management & supervision) services.	Bill EDS on paper (with X codes until further notice) with EOB after benefits are exhausted for the first claim. All subsequent claims can be billed to EDS on paper with the new COB form.	Bill EDS on paper (with X codes until further notice) with EOB after benefits are exhausted for the first claim. All subsequent claims can be billed to EDS on paper with the new COB form.
RIte Care Plans	N/A	Plans use national codes for all EI services.	N/A
Commercial Carriers	N/A	Bill the first $5k in a calendar year to Commercial Carriers for all EI services using national codes or based on Commercial Carrier specifications.	Bill the first $5k in a calendar year to Commercial Carriers for all EI services using national codes or based on Commercial Carrier specifications.